Rock-a-Bye Baby

EI Services for the youngest, smallest and most vulnerable infants
Children’s of Alabama

Sheree York, PT, DPT, PCS

Chantel Jno-Finn, PT, DPT

Lauren Lovett, PT, DPT

Christy Moran, OTR/L
Special Guests

Anna Ruth McCalley, MS, OTR/L, Mom
&
Frances
Objectives

- Recognize the eligible diagnoses for premature and medically complex infants
- Recognize the risks associated with complex medical conditions
- Select and complete appropriate evaluations of these infants
- Provide family-centered EI services designed to support the families and promote the development and care of these infants
AEIS Qualifying Medical Diagnoses/Conditions

- Achondroplasia
- Agenesis of Corpus Callosum
- Agyria (Lissencephaly syndrome (Miller-Dieker syndrome))
- Albinism
- Amniotic Band syndrome
- Anencephaly
- Angelman’s syndrome
- Anophthalmia
- Apert syndrome
- Aplasia of the brain (brain malformation/abnormality)
- Arnold-Chiari syndrome
- Arthrogryposis
- Asperger syndrome/disorder
- Asphyxiating Thoracic Dystrophy (Jeune syndrome)
- Attachment disorder
- Auditory Neuropathy
- Autism/Autism Spectrum disorder
- Bardet-Biedl syndrome
- Beckwith-Wiedemann Syndrome

- Brain injury/degeneration
- Brain malformation/abnormality
  - Macroencephaly
  - Macrogyria
  - Megalencephaly
  - Microcephaly
  - Microgyria
- Cataracts
- Cerebral Palsy (all types)
- CHARGE syndrome
- Chiari Malformation
- Childhood Depression
- Childhood Disintegrative disorder
- Coloboma
- Cone Dystrophy
- Connexin 26
- Cornelia de Lange syndrome
- Cortical vision impairment (vision loss/impairment)
- Cri-du-Chat syndrome
- Cytomegalovirus (CMV)
- Dandy Walker syndrome/variant
- De Morsier syndrome (Septo-Optic Dysplasia)
### AEIS Qualifying Medical Diagnoses/Conditions

- Developmental Apraxia
- DeWayne Syndrome
- DiGeorge syndrome
- Dilantin syndrome (Fetal Hydantoin syndrome)
- Down Syndrome (Trisomy 21)
- Edwards syndrome (Trisomy 18)
- Encephalomalacia
- Encephalopathy
- Epilepsy (seizure disorder)
- Esotropia
- Exotropia
- Fetal Alcohol syndrome
- Fragile X syndrome
- Genetic/Chromosomal malformation/abnormality (not listed)
- Glaucoma
- Glue Ear
- Hearing Loss/Impairment
- Heart Disease/Defect (not listed)
- Hemiplegia
- Herpes Simplex Virus (HSV)
- Holoprosencephaly (Arhinencephaly)
- Holt Oram syndrome
- Hunter Syndrome
- Hurler Syndrome
- Hydranencephaly

- Hydrocephaly (with or without shunt; congenital or acquired)
- Hypoplastic Left Heart Syndrome
- Incontinentia Pigmenti
- Infantile spasms (seizure disorder)
- Intraventricular Hemorrhage (IVH) Grade III or IV
- Klinefelter’s syndrome
- Landau-Kleffner syndrome
- Lead (elevated blood levels)
- Leber Congenital Amaurosis (vision loss/impairment)
- Leukodystrophy
- Meningitis
- Menkes syndrome
- Mercury Poisoning
- Microphthalmia
- Microtia
- Mobius syndrome
- Mucopolysaccharidosis
- Muscular Dystrophy
- Myasthenia syndrome-congenital
- Myopathy
- Neurological Disease/Defect (not listed)
- Neurofibromatosis
- Noonan’s syndrome
- Nystagmus
- Opitz G/BBB syndrome
- Optic nerve hypoplasia or atrophy
AEIS Qualifying Medical Diagnoses/Conditions

- Osteogenesis Imperfecta
- Other (not listed)
- Pallister-Killian syndrome
- Patau syndrome (Trisomy 13)
- Pediatric Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS)
- Periventricular Leukomalacia (PVL)
- Pervasive Developmental disorder (PDD and PDD-NOS)
- Peters Anomaly
- Phelan McDermis syndrome
- Phiffer syndrome
- Porencephalic Cyst
- Prader-Willi syndrome
- Prematurity (26 weeks or less gestation or 1000 grams or less and 18 months chronological age or younger)
- Prune Belly Syndrome (Eagle – Barrett Syndrome)
- Reactive Attachment disorder (RAD)
- Retinoblastoma
- Retinopathy of Prematurity (ROP)
- Rett syndrome
- Roberts syndrome (Pseudothalidomide syndrome)
- Rubella-congenital
- Rubenstein-Taybi syndrome
- Schizencephaly

- Seizure disorder/uncontrolled or poorly controlled seizures
- Septo-Optic dysplasia (De Morsier syndrome)
- Shaken Baby syndrome
- Smith-Lemli-Opitz syndrome
- Spina Bifida (Myelomeningocele/Meningomyelocele)
- Spinal Muscular Atrophy (SMA)
- Spinocerebellar Ataxia
- Stickler syndrome
- Srabismus
- Stroke, Prenatal or Neonatal
- Sturge Webber syndrome
- Tay-Sachs Disease
- Traumatic Brain Injury (TBI)
- Traumatic Retinal Detachment
- Treacher-Collins syndrome
- Tuberous Sclerosis
- Turner syndrome
- Usher Syndrome
- VACTERL/VATER syndrome
- Ventriculomegaly
- Vision Loss/Impairment
- Waardenburg-Klein Syndrome
- Weaver syndrome
- Williams syndrome
What can we do?

Vermont Oxford Network Manifesto

- Family-centered
- Safe
- Effective
- Timely
- Socially and environmentally responsible

- Habits in daily practice
  - Evidence based practice
  - Change
  - Systems thinking
  - Collaborative learning

- Accountability
- Respect for team members and family
Functional Brain Plasticity

- Functional Plasticity
  - Resilience and physiological response to stress
    - Promoting change while promoting stability
  - Stress
    - Positive stress can strengthen
    - Toxic stress weakens
    - Tolerable stress
      - Modulated by supportive caregiving
Evidence: Early Experiences on Brain Development

- Safe and Secure Environments
- Nutrition
- Stable and Responsive Relationships
- Behavior
Promoting Developmental and Family-Centered Care

It Takes a Team for best outcomes
The Premature Infant

Automatic Eligibility

• Prematurity
  – 26 weeks or less gestation
  – 1000 grams or less
  – 18 months chronological age or younger
Adjusted Age for Premature Infants

- Through 18 months of life
- Chronological age – weeks premature = adjusted age
- Infant born at 26 weeks gestation was 14 weeks early
- At 10 months: 10 - 3.5 = 6.5 months
Biological Risk Factors for Developmental Delay

- Prematurity
- Low birth weight
- Neurological damage
- Chronic illness
- Genetic disease
- Seizures
- Malnutrition
- Alcohol/drug use
Outcomes in Infants Born Prematurely or Requiring NICU

• Susceptible to respiratory tract infections and asthma
• GI problems:
  – Reflux common
  – Difficulty coordinating suck-swallow-breathe
  – May need special formula and strategies for introducing solid food to ensure nutrition and growth
• Difficulty with state control and self-regulation
  – Irritability or sleeping “all the time”
  – Easily stressed
    • Yawning, hiccupping, sneezing, gaze aversion
Outcomes in Infants Born Prematurely or Requiring NICU

• Severe levels of impairment are generally apparent by 2 years of age

• Mild-moderate disabilities may not be apparent until preschool or school-age, even adolescence
  – DCD
  – ADHD
  – Cognitive delays
  – Behavioral/social issues
Neurodevelopmental Outcomes of Prematurity

- Premature birth is potentially disruptive to multiple aspects of neurodevelopment, especially with:
  - Intraventricular hemorrhage
  - Infection
  - Chronic lung disease
Neurodevelopmental Outcomes of Prematurity

• Aspects of NICU care that improve survival but may worsen long-term neurological outcomes
  – Mechanical ventilation
  – Supplemental oxygen
  – Bright lights
  – Noisy alarms
  – Painful procedures
  – Medications
Risk of Neurodevelopmental Problems

- Risk of neurodevelopmental problems proportional with gestational age and birth weight
- Chance for abnormal development increases with lower gestational age and smaller birth weight
Neurodevelopmental Impairments: Extremely Premature (<26 weeks gestation)

- Rates high
- Rates inversely related to gestational age 22-25 weeks
  - Death and disability at 22 weeks approaches 100%
  - Moderate to severe disability at 22-23 weeks >50%
  - Rates of disability decrease at 24-25 weeks
  - Rates of bilateral deafness and blindness increase with decreasing gestational age
- Potential for recovery with increasing age when in good environments with access to intervention and support services
2010 Systematic Review

• In 11 studies published after 1990 reporting the prevalence of motor impairment in children born preterm (<37 weeks gestation)
  – 3-4 times > general population
  – Mild-moderate impairment 40.5/100
  – Moderate impairment 19/100
Optimizing Neurodevelopmental Outcomes after Prematurity

- Best medical practices
- Teaming
- Developmental follow-up
- Family support
- Early intervention or nurse home-visits: focus on improving parenting through daily routines, relationship-based activities, reinforce comfort, create safe experiences, and address stressors
Congenital Heart Disease

Circulation of Blood Through the Heart:
Davis

- Normal deliver at 39 WGA
- Developed fever and poor feeding at day 3 and transferred from OSH for abnormal Echocardiogram
- Berlin Ventricular Assistive Device (VAD) placement
- Head US showed multiple focal hemorrhages
- Heart transplant at 5 months requiring multiple bypass runs and Extracorporeal Membrane Oxygenation (ECMO) x2 days
- Post-pump chorea
- G-tube placement
Commonly Seen Diagnoses

- Tetrology of Fallot (TOF)
- Atrial Septal Defect (ASD)
- Ventricular Septal Defect (VSD)
- Interrupted Aortic Arch (IAA)
- Hypoplastic Left Heart Syndrome (HLHS)
- Coarctation of the Aorta

- Transposition of the Great Arteries (d-TGA)
- Patent Ductus Arteriosus (PDA)
- Cardiomyopathy
- Atrioventricular Septal Defect (AV Canal)
- Truncus Arteriosus
CHD and the Brain

- With severe defects (i.e., single ventricle, d-tga) there are often brain abnormalities before surgery
  - There is increasing evidence of impaired neurodevelopment in utero
  - Smaller head circumference and decreased brain maturation
- Acquired brain injuries related to hypoxia, prolonged bypass, cardiac arrest
- While IQ often falls in the normal range, there also often neurodevelopmental impairment
Who is at risk?

- The presence of CHD and any of the following increases the probability of developmental delay:
  - Prematurity (<37 weeks)
  - Genetic syndrome/abnormality
  - ECMO, VAD/Berlin
  - Prolonged or multiple bypass runs
  - Heart transplant
  - CPR
  - Prolonged hospital stay (>2 weeks)
Congenital Syndromes Associated with CHD

- Down syndrome
- Charge syndrome
- Cri du chat
- 22q11.2 Deletion/DiGeorge syndrome
- Noonan syndrome
- Turner syndrome
- Marfan syndrome
- Alagille syndrome
- Trisomy 13, 18
DiGeorge Syndrome

- Chromosome 22q11 deletion
- >50% Interrupted Aortic Arch
- >35% Truncus Arteriosus
- Cleft Palate
- Poor immune function
- Developmental Delay
- Behavioral and emotional problems
Down Syndrome

- Trisomy 21
- AV Canal Defects - ASD, VSD, abnormalities in the mitrial and/or tricuspid valve
Hypoplastic Left Heart Syndrome (HLHS)

- 1.2-1.5% of all congenital heart defects
- Universally fatal without surgery
- Rate of occurrence increased in patients with Turner Syndrome, Noonan Syndrome, Smith-Lemli-Opitz Syndrome, and Holt-Oram Syndrome
- 25% of infants with HLHS have chromosome abnormalities
Surgical Intervention - 3 Stages

- Norwood Procedure - 30% mortality rate
  - Traditional Norwood with BT Shunt
  - Sano Norwood

- Bidirectional Glenn

- Fontan
Do’s and Don’ts

DO

• Encourage normal developmental through play and positioning

• TUMMY TIME- progress as tolerated

• Recognize signs of low cardiac output during activity

DON’T

• Pick a child up under their arms or pull on their arms for 6-8 weeks after surgery

• Assume they don’t need therapy because family thinks they are doing well considering the trauma they have gone through
Signs of Low Cardiac Output

- Cool skin, prolonged capillary refill
- Mottling, pallor
- Sweats with exertion
- Diminished peripheral pulses
- Decreased urine output
- Change in responsiveness
- Tachycardia
- Late Signs: hypotension, bradycardia
A Case Study: Davis
Follow Up

- Newborn Follow up/Cardiac Clinic
- Outpatient Follow Up
- Referral to Early Intervention
Why Do Children with CHD Need EI?

- Developmental delay
- Poor feeding
- Poor sensory processing and integration
- Family support
Medical Conditions Affecting Feeding

Things you should know
Tracheostomy

- Tracheotomy: is a surgical procedure to create an opening through the neck into the trachea.

- Tracheostomy tube placed in the opening to provide an airway and to remove secretions.

- A child can have a tracheostomy with or without mechanical ventilation (ventilator)
Tracheostomy

- Tracheostomy without mechanical ventilation for structural anomalies like:
  - subglottic stenosis
  - tracheomalacia
Tracheostomy

- Tracheostomy with mechanical ventilation: when respiratory support is needed
  - BPD: bronchopulmonary dysplasia
  - SMA: spinal muscular atrophy
  - central hypoventilation syndrome
BPD

BPD = *bronchopulmonary dysplasia*

- Occurs in premature infants with respiratory distress syndrome who need mechanical ventilation for extended periods of time
- Abnormal development of lung tissue, specifically in the smaller airways and alveoli.
- ELBW babies (<1000g or 2.2lbs) at most risk
TEF

- *Tracheoesophageal fistula* = abnormal connection between the esophagus and the trachea

- Most often associated with esophageal atresia – where the esophagus does not connect with the stomach.
• *Necrotizing enterocolitis* = the wall of the intestine becomes infected, swollen, and can die

• Antibiotics and bowel rest may solve the issue if tissues are swollen

• Any dead tissue must be removed

• An ostomy may be created if the remaining intestines cannot be reconnected at that time
NEC

• With ostomy the stool is collected in a bag then removed.
• At some point the bowel will be reconnected in a “Take Down” surgery.
• Short Bowel syndrome occurs when a large amount of the small intestine has been removed.
• The small intestines are not able to absorb enough nutrients to stay healthy and gain or maintain weight.
G-tube

• A *gastrostomy tube* is a tube inserted through the abdomen into the stomach to deliver nutrition and hydration.

• Nutrition given
  – *bolus* – a large amount every 3/4 hours
  – *continuous* – a small amount continuously going in over a long period of time 20 to 24 hours
Feeding Problems Occur

- Premature infants especially with BPD, TEF, NEC, and short gut

- Hospitalized for a long time with negative oral experiences – ET tubes, CPAP, HFNC, nasal cannula, nasogastric tubes, salem sumps, and tape.

- Prolonged time without orally feeding at all.
Feeding Problems cont.

• Breathing difficulties complicate feeding. If a baby cannot breathe they will not eat. Breathing always wins.

• GERD = Gastroesophageal Reflux
  – common in babies with TEF
  – can be related to oral aversion
Oral Aversions - Negative oral experiences associated with a prolonged hospitalization

- ET tubes
- CPAP
- HFNC
- Nasal cannula
- Increased Resp. Rate
- NG tubes
- Salem sumps
- Reflux
- Emesis
- Continuous feeding
- Prolonged time without oral feeding
Feeding Suggestions

- Feeding needs to be related to corrected age and developmental age.
  - A 3-4 month old should not eat or taste hot sauce, BBQ sauce, or pickle juice.
  - should be taking formula or breast milk only.
  - Baby food feeding does not begin until around 6 months for a typical healthy baby and will be delayed if a baby is younger developmentally.
  - If a baby has NEC or short gut this may be delayed even more.
Feeding Suggestions

• Babies that have NEC and short gut need to limit sugar.

• First foods should not be sugary foods.

• Sugar causes them to stool. They stool too quickly as it is and do not absorb enough nutrients. They need to keep food in their intestines as long as they can.
Feeding Suggestions

• Babies with G-tubes and oral aversions may take baby food better than liquid. They can organize the bolus for swallowing and breathing better than liquid.

• After they get good at baby food they may be able to do liquid. Keep in mind developmental age when considering baby food.
Feeding Suggestions

• Babies with trachs, BPD, NEC, gut surgeries, on oxygen and with congenital heart disease tend to have more sensory aversions to food, touch, holding...

• Remember touch to the hands comes before touch in the mouth.
Feeding Suggestions

- **Do not** allow mouthing/chewing on dog toys.
- Dog toys are not regulated by the FDA or the Consumer Product Safety Commission and can be harmful to babies.
Case Study - CL
Neurological Conditions

- Acute Cerebellar Ataxia
- Agenesis of Corpus Callosum
- Arnold-Chiari Syndrome
- Brain Injury*
- Cerebral Palsy
- Cytomegalovirus (CMV)
- Fetal Alcohol Syndrome
- Myelomeningocele (Spina Bifida)
- Microcephaly
- Schizencephaly
- Shaken Baby Syndrome
Conditions Associated with Brain Injury

- **Periventricular leukomalacia**: white matter brain injury characterized by necrosis of white matter near the lateral ventricles.
- **Severe Intraventricular Hemorrhage (grades III and IV)**: bleeding into the ventricles of the brain.
- **Hydrocephalus**: build-up of fluids in the brain, puts pressure on other structures.
Conditions Associated with Brain Injury

• Porencephalic cysts: cysts or cavities within the cerebral hemispheres
• Congenital malformations: portions of brain missing or mis-shapen
• Hypoxic Ischemic Events: caused when an infant’s brain does not receive enough oxygen and blood, usually term infants, may be treated with head cooling
Brain Injury: Severe Disability in 1/3 EBLW Infants

8.5% with cerebral palsy
22.3% cognitive delay
Neurological Red Flags

Behavior/Parent Reports

- Too good, never cries VS always irritable
- Floppy, stiff, just right
- Loves to stand
- Arches
- Head always to one side/flattened head
- Arms held back, doesn’t bring together
- Only uses one side of body
- Always on toes
Red Flags/Difficulty with:

- **Feeding:**
  - swallowing, sucking and chewing
  - developing coordinated tongue movements for speech
- **Activities of daily living:**
  - achieving independence in feeding
  - Dressing/bathing
  - Toileting
- **Cognitive skills**
  - Understanding relationships between objects, people, time and space
  - Developing problem-solving and coping strategies
Torticollis

- **Torticollis** – unilateral shortening of the SCM (neck muscles)
  - Positional
    - Usually just head tilt preference
    - Can be managed with gentle ROM and changes in infant’s environment
  - Muscular
    - Congenital
    - Head tilt and rotation are often present
    - Infant has difficulty moving head through full ROM on their own
Torticollis

Congenital torticollis

Head tilted toward affected muscle

Chin point away from contracted muscle

Contracted SCM muscle
Plagiocephaly

• Flat area that occurs on the side or back of the infant’s head as a result of lying in one position for too long
  – Examples:
    • Leaving infant in carseat/carrier throughout the day
    • Always lying on back or one side of body
  – Can result in abnormal head shaping
Plagiocephaly

Normal-Shaped Head

- Flat area
- Ear is forward
- Forehead bulges

Severe Flat Head

11-03-11
12-27-11
Preventing Plagiocephaly

• When your child is awake, change their position often.
  – Work on sitting, roll, tummy time activities

• Take note of amount of time baby spends in a container (i.e., stroller, carrier, carseat) with head flat against a surface
  – Try to decrease this as much as possible

• Remember: Back to Sleep, Tummy to Play
Positioning and Handling
“Container Lifestyle”

- Sustained Supine Positioning
- Introduction of convertible infant carriers
Who Receives EI Services?

Children birth to three years of age who have a:

Qualifying Diagnosis
- medical, documented by physician
- 1 five-part developmental eval

Qualifying Delay
- based on 2 evaluations
  - 2 five-part developmental evals
    OR
  - 1 five-part developmental eval AND 1 discipline-specific eval
- conducted by 2 qualified professionals from different disciplines
- 25% or greater delay in at least one area on both instruments

AEIS, The Message Revitalized: Journey II
Assessment Tools

• Informed Clinical Opinion
• Formal Measures
  – DAYC-2
  – PDMS-2
  – ELAP
• General knowledge of infant/child development
Informed Clinical Opinion

Informed Clinical Opinion is appropriate when:

• No standardized measures exist or are appropriate for a given developmental area or child’s age

• Borderline delays (22-24%) on 2 procedures with professional opinion of likelihood to result in more substantial delays
  – Based on identified impairments & documented prognosis

AEIS, The Message Revitalized: Journey II
Informed Clinical Opinion cont’d

• Physical or mental condition that doesn’t meet standards for qualifying diagnosis, documented by MD or therapist

• Must be given by specialist (PT, OT, SLP) in area of delay

• Only valid for 6 months
Evaluating Daily Routines

- Feeding
- Bathing
- Sleeping
- Awake times
- Tolerance of handling
- Ability to tolerate sensory input
Using Daily Routines

• Environmental factors
  – Physical
  – Social
  – Family and Community Culture

• Personal factors
  – Personality features of the infant which are not part of the health condition or state
Developmental Care

- Social-emotional
  - Attachment/bonding
- Adaptive
  - Feeding
  - Sleeping
  - Calming
  - Positioning
Family Supports

- Understanding the need for medical follow-up
- Developmental next steps
- Supports to promote development in all areas
- Teaching/modeling developmentally appropriate care-giving
- Serve as a resource
  - Provide information about available resources: CRS, outpatient therapists
  - Developmentally appropriate toys and positioning
- Listen: for understanding, comfort, support
- Practical childcare
Facilitating Communication & Cognitive Skills

- Studies show families are the key components of change.
- Optimal time to enhance skills to enhance parent-infant relations is in the first two years.
  - Need to develop an interactive, responsive relationship.
- Recognition of infant signaling is important.
  - A non-verbal communication strategy used to facilitate a response in the parent.
- Parents of premature infants do not seem to be as confident in reading their infants' cues & signals.
Responsive Engagement
Facilitating Communication & Cognitive Skills

• Exposure to speech and language is necessary for the development of language
  – Infant develops ability to perceive speech long before ability to speak words
Intervention Strategies to Facilitate Speech-Language and Cognitive

- Feeding is one of the earliest opportunities to develop these skills
- Encourage parents to talk to their children
- Suggest parents read aloud if they have infant who is slow to interact
- Provide parent education about appropriate play to stimulate language development
Key Ingredients For Effective Follow-up with Greatest Impact on the Future

- Time-sensitive and along a continuum of care
- Trusting relationships
  - Family-centered and culturally sensitive care
- Professionals with knowledge, skills, and abilities
- Collaborative and interdisciplinary systems of care
- Currency of best practice
Where Developmental “Follow-Up” Happens

- Prior to discharge from NICU
- High risk or newborn follow-up clinics
- Early Intervention programs
- Outpatient therapy services
- Community screenings
- Multi-center outcomes research
Developmental Follow-Up

• Clinics
  – Newborn follow-up: <1000 grams, <30 weeks, HIE: head cooling, specific studies
  – Specialty clinics: BPD, Neurology, GI, Pulmonary
  – Outpatient PT and/or OT: for monitoring, addressing specific needs
  – Early Intervention: diagnosis or delay >25%
What Needs to Happen at Every Interaction: clinic, bedside, EI or outpatient therapy

- Listen to parents and caregivers
- Evaluate and re-assess
- Anticipatory guidance
- Referrals as appropriate
Summary: Implications

• Developmental Care in the NICU
• Parent Education: early and ongoing
• Screening: early and ongoing
• Know resources
• Initiate intervention as early as possible
• Continued support of child and family
References


References


Additional References


More Additional References


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- www.sundancesolutions.com
- www.DandleLION.com
- www.choa.org Tummy Time Tools
- www.pathwaysawareness.org
Websites

• Harvard Center for Developing Child
  http://developingchild.harvard.edu/key_concepts/brain_architecture/

• The Ounce http://www.theounce.org/#

• Zero to Three
  http://www.zerotothree.org/child-development/brain-development/
Resources

- APTA, Section on Pediatrics:  www.pediatricapta.org
- ASHA:  www.asha.org
- AOTA:  www.aota.org
- ECTA:  www.ecta.org
- Frank Porter Graham Center Resources:  http://www.community.fpg.unc.edu/connect-modules/learners
- Results Matter Video Collection:  www.cde.state.co.us/resultsmatter/RMVideoSeries.htm#02
- Journal of Early Intervention
- Young Exceptional Children
- Infants & Young Children
- Topics in Early Childhood Special Education
- DEC Conferences
- Kids’ Health.org
- AEIS: The Message Revitalized – Journey II
Pediatric Care

Our promise to the children of Alabama